American Hospital Association

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Via email: Donald.Romano@cms.hhs.gov

Dear Mr. Romano:

Thank you for the opportunity to comment on your agency's development of a proposed strategic and implementation plan for addressing certain specialty hospital issues as required by Section 5006 of the Deficit Reduction Act of 2005 (DRA). Specifically, you have asked for comments and suggestions on your proposed approach to developing the plan as described during the March 8 Open Door Forum. To avoid any confusion, our comments below refer to physician-owned limited-service hospitals, the subset of specialty hospitals affected first by the moratorium and now by Sec. 5006 and the continued suspension.

Overall, AHA believes that CMS needs to pivot from simply "studying" the issues (as described in your announcement of the March 8 call) to actively "addressing" the issues (as described in Section 5006) raised by the rapid expansion of physician ownership and self-referral. Our plain reading of Section 5006 in the DRA is that Congress now wants to know what CMS plans to do about the issues.

More specifically, Congress has asked that several issues regarding physician-owned limited-service hospitals be addressed in the plan and accompanying recommendations. In the comments below we have grouped the issues into three areas: physician investment, provision of care to the poor, and enforcement of Medicare requirements.

Physician Investment

Congress directed CMS to address physician investment issues related to the proportionality of investment return, bona fide investments, and annual disclosure of ownership information. During the call, you asked for input on how these terms should be defined. **AHA recommends**

that CMS borrow from the definitions used by the Office of the Inspector General (OIG) in establishing their criteria to judge whether the financial interests of physicians fall into the investment interest safe harbor under the federal anti-kickback rules. Those criteria include, among others:

- Ownership limitations on tainted investors who are in a position to influence patient referrals.
- A definition of bona fide investments used to help identify "sweetheart" deals.
- How to measure whether an investor's return is proportionate to his/her capital contribution.

We believe these criteria would be a useful place to start in evaluating physician investment interests. We also believe that it would be useful for CMS to seek the OIG's insights into issues they have encountered in looking at ownership interests.

CMS' plan to rely predominantly on information already in hand from its study last year and from applications for grandfathering under the previous moratorium is not sufficient to address the issue of physician investment. As we indicated during the call, data on physician ownership interests is almost non-existent and is the primary area where we believe CMS needs to collect data from limited-service hospitals to respond to Section 5006 of the DRA. The previous studies did not collect much, and the applications for grandfathering under the moratorium are unlikely to have enough specific information on investment interests. The applications are focused on whether the facilities met the test of having been sufficiently under development so as to avoid the moratorium. For example, issues like "proportionality of investment" could not be addressed with data from a facility not yet operational.

AHA believes this current evaluation needs to be based on detailed information on physician investments and returns on those investments, coupled with each physician's volume of referrals, revenue generated, profit distribution, and any compensation paid for management or other functions. We do not believe it will be sufficient to examine different models for physician investment, as suggested in your methodology. This more detailed information should be readily available to CMS within a 30-day time frame under the terms of the final Stark II rules under the recordkeeping and reporting provisions. Entities are required to maintain such information and, on request from CMS, to supply it within 30 days (see 42 CFR 411.361). **Last week we provided you with a list of questions for physician-owned limited-service hospitals to obtain such information. I am attaching a copy of those questions**.

AHA also recommends disclosure of physician investment information to individual patients of physician-owners and to CMS for posting on its Web site. This would ensure that any physician's investment interest is transparent and available to the communities in which they operate.

<u>Provision of Charity Care and Service to Medicaid Recipients</u>

Congress also directed CMS to evaluate the amount of charity care provided by physician-owned limited-service hospitals and the amount of care provided to Medicaid recipients. In doing so, it is important not to confuse the issue by adding taxes paid to governments (as was the case in

CMS' report last year). Such taxes generally do not go to care for the poor, but to more broad-based local government revenue needs. **AHA believes Congress is very tightly focused on care to people of limited means who need assistance and CMS' evaluation should be as well. AHA also recommends that in looking at charity care, CMS look at the cost of the care, not the charges.** For some time, AHA data on uncompensated care (which includes both charity care and bad debt) has been adjusted to reflect the cost of care by applying each institution's cost-to-charge ratio. **Given the state of Medicaid payment in most states, AHA also believes CMS should include the difference between Medicaid payments and the cost (not charges) of care to Medicaid recipients.**

The limited-service hospital representatives on the call suggested that Medicaid and charity care information be adjusted for the service mix of the facility when comparing to community hospitals. We believe this comment misses the point. Part of the concern with these facilities is that they avoid caring for less well insured patients and limit their services to create a more favorable payer mix (e.g., elective surgical care). We think it is important to look at the provision of care for low-income populations for each facility as a whole.

Enforcement

With respect to enforcement issues, **AHA recommends that the strategic plan describe how enforcement is currently conducted (that is, the process for ensuring compliance) and how to address some apparent weaknesses. These include: compliance with hospital-level standards, compliance with the current suspension of new limited-service hospitals entering the Medicare program, and compliance with relevant physician self-referral and anti-kickback requirements.**

Clearly, the work undertaken by CMS to reevaluate whether many surgical and orthopedic hospitals actually meet the definition of a hospital should be reflected in the plan. Also, the recent case in Oregon regarding the lack of physician coverage for a patient just out of surgery was especially disturbing. That case raised significant issues including:

- Compliance with basic standards of care;
- The lack of any standards governing how transfers of patients with complications are made from specialty hospitals to community hospitals when the specialty hospitals are not subject to EMTALA;
- Whether patients have any idea when going to a specialty hospital that complications will generally result in transfers to full-service hospitals due to service limitations; and
- How the hospital was allowed to open during the moratorium.

We hope you find these suggestions useful. If you have any questions, please contact Ellen Pryga, director, Policy at (202) 626-2267 or epryga@aha.org, or Caroline Steinberg, vice president, Trend Analysis at (202) 626-2329 or csteinberg@aha.org.

Sincerely,

Carmela Coyle
Senior Vice President, Policy
American Hospital Association

Attachment

Proposed Questions for Physician-owned Specialty Hospitals to Understand Investment Structures

Organizational Background

1. When did the specialty hospital begin operations?
2. When did the specialty hospital begin servicing Medicare patients?
3. Did the facility previously have a Medicare provider number? As what type of facility (e.g. ASC, hospital)?
4. What is the legal structure of the hospital?
5. Describe the categories of investors:
   - Percent owned by physicians and number of physician investors
   - Percent owned by other types of investors (full-service hospital, specialty hospital corporation, non-physician individuals, venture capital firm, etc.), number of such entities and ownership share
   - Associated documents: shareholder agreements, prospectus, offering memos, slide presentations explaining investment to investors. *[Note: these more detailed materials could be used to answer questions that arise after review of survey responses.]*
6. Describe the debt structure
7. Is any debt held or guaranteed by any non-physician owners?

Management Structure

8. What role do physician owners play in facility management? How many physician-owners hold salaried positions with the facility, have management contracts, or are otherwise compensated for administrative services?
9. Does the facility employ or contract with physician-owners for clinical activities (e.g. pay physician-owners for on-call time)?

Referral Patterns

10. How many physicians have admitting privileges? What percent are owners?
11. What is the total gross and net revenue derived from referrals of owner-physicians? Non-owner physicians?
12. What specialty types are represented by physician-owners? (number of physicians by specialty type)
13. Are there any physician-owners that do not provide services or refer patients to this facility? Status (active or retired)?
14. Does the facility have any referral requirements?

Detailed Information on Investors

15. Complete listing of current and former owners including the following information for each:
    - Name
    - UPIN if physician-owner
    - Medical specialty or subspecialty

- Medical license number if physician-owner
- Date became owner
- Percent ownership stake
- Capital contributed
- Percent of total capital contributed
- Ownership share
- Profit and/or equity distribution for last fiscal year (dollars and percent of total)
- Cumulative profit or equity distribution since inception (dollars and percent of total)
- Any management positions held
- Salary compensation
- Other non-salary compensation (management contracts, etc.)
- If divested, nature of transaction and consideration received
- If physician, total number of referrals for last fiscal year
- If physician, gross revenues generated from referrals
- Minimum referral requirements for physician-owners if any
- Amount of any loan received by physician , repayment schedule, interest rate

Description of Service Offerings

[Note: these questions relate more to the issue of whether the entity is a "hospital" than the strategic investment plan]

16. Describe the facility and service offerings:
    - Number of inpatient beds
    - Complete listing of service offerings
17. Patient volumes
    - Inpatient discharges
    - Outpatient surgeries
    - Emergency department visits
    - Other outpatient visits
18. Revenue Mix
    - Gross revenues from inpatient services
    - Gross revenues from outpatient services
19. Payer mix (gross revenues and net revenues)
    - Medicare
    - Medicaid
    - Worker's compensation
    - Other third party
    - Self-pay
    - Charity care